



PROVIDER ACCOUNTS CHANGE FORM

**PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING
THE PROVIDER ACCOUNTS CHANGE FORM.**

1) BUSINESS ADDRESS (Physical location of the business)

Complete this section with your OLD and NEW business address. This is the physical location of your business. It cannot be a PO box.

IF YOUR BILLING ADDRESS DOES NOT CHANGE, WRITE SAME IN OLD ADDRESS BOX 2.

2) BILLING ADDRESS (Address as it appears on your bill)

Complete this section with your OLD and NEW billing address. This is where payments should be mailed.

3) PROVIDER ACCOUNT TERMINATION

Please complete the reason for Provider Account termination, name of provider to be terminated, provider number and effective date of the termination.

Tax ID (EIN) Number Change:

If you have a tax ID number change, please complete a new provider application and Form W-9 and return it to the appropriate address on the form. Please include a list of all providers with their provider account numbers who should be changed to the new tax ID number. The Form W-9 must show the effective date of the change.

Tax ID Name or Address Change ONLY:

If you have a tax ID name change only, please complete a Form W-9, attach a note indicating it is a name change only, and return it to Provider Accounts at P. O. Box 44261, Olympia, WA 98504-4261. An address change form does not need to be completed along with the Form W-9 unless you have an address change other than for tax purposes.

All forms referenced above can be located on the Internet at:

www.lni.wa.gov

**Forms are listed under the
Provider Payment Information option**

VOCATIONAL PROVIDERS ONLY

Please refer to vocational change forms at
www.lni.wa.gov



STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44261 Olympia, WA 98504-4261

Provider Accounts Change Form

To change your mailing address, physical location, or terminate a provider account please complete the form below. Please refer to the instructions when making changes. The provider or the provider's representative must sign the form to initiate any changes.

Send this form to:

Department of Labor and Industries
Provider Accounts
PO Box 44261
Olympia WA 98504-4261

Phone: (360) 902-5140

FAX: (360) 902-4484

Provider name (<i>Name of Individual/Group/Firm that change applies to - please print</i>)		Phone:
Individual Provider ID	Group/Firm Provider ID	Federal Tax ID

1) BUSINESS ADDRESS (Physical location of the business.)

Old Business Address	New Business Address
<i>(where you would like to receive general correspondence; cannot be a PO Box)</i>	
Address	Address
City State ZIP	City State ZIP

2) BILLING ADDRESS (As it appears on your bills submitted to L&I and where payments should be mailed.)

Old Billing Address	New Billing Address
<i>(where you would like warrants mailed)</i>	
Address	Address
City State ZIP	City State ZIP

3) TERMINATION

Provider Account Termination		
I wish to terminate the provider account number below for the following reason:		
Provider Name	Provider Number	Effective Date

PLEASE SIGN AND DATE AUTHORIZING CHANGES INDICATED ON THIS FORM

Date	Signature
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